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March 14, 2014

Green Mountain Care Board
State of Vermont
89 Main Street, Third Floor, City Center
Montpelier, VT 05620

Re: Blue Cross Blue Shield of Vermont – 2014 BCBSVT Provision for Large Claims and Stop Loss Filing (SERFF # BCVT-129374060)

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2014 Blue Cross Blue Shield of Vermont (BCBSVT) Provision for Large Claims and Stop Loss Filing and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. BCBSVT is a non-profit hospital and medical service corporation. BCBSVT provides large group coverage to employers in Vermont.

2. The present filing is a factor filing that modifies the large claim factors and cost of reinsurance for Merit groups and the pooling charges for Cost Plus groups. These factors are used to estimate the impact of large health claims when determining rates from a company's experience. The requested factor changes represent a subset of the overall rate charged for Merit and Cost Plus groups. The other subsets are addressed in other filings.

3. This filing addresses two types of BCBSVT large groups, Merit and Cost Plus. There are approximately 33,200 Vermonters affected:
   - Merit Groups: 29,800 Vermonters
   - Cost Plus Groups: 3,400 Vermonters

4. The overall rate impact of this filing broken out by factor change and group is:
   - Merit Groups
     - Large Claim Factors: 1.0% ($4.31 PMPM).
     - Cost of Reinsurance: $0.51 PMPM (increased from $0.54 PMPM to $1.05 PMPM)
   - Cost Plus Groups
     - Pooling Charges: 0.9% ($4.33 PMPM).

Standard of Review
Pursuant to Green Mountain Care Board Rule 2.000 Health Insurance Rate Review, this letter is to assist the Board in determining whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the law, and is not excessive, inadequate, or unfairly discriminatory.

Summary of the Data Received
BCBSVT provided the methodology used to create the data set of historical experience to be used to develop the proposed factors. BCBSVT used 2013 Milliman Health Cost Guidelines to create a set of factors that would be blended with company claim experience when that experience was not statistically credible. An exhibit was provided showing the actual charges/factors and expected charges/factors from the prior filings. BCBSVT also provided the methodology for determining the net cost of reinsurance PMPM.

Company's Analysis
1. *Large Claim Factors and Pooling Charges*: The large claim factors and pooling charges are used to estimate the impact of large health claims when determining rates from a company's experience. Large claims can vary significantly from year to year. To reduce this volatility, issuers typically remove claims over a certain amount ("attachment point") from a group's experience to exclude outliers that would affect a group's future rates. An expected average large claim amount is added back to the group's claims that are lower than the attachment point to determine the total claims for a group. The expected amount of large claims is developed from the past experience of all BCBSVT Merit and BCBSVT Cost Plus groups as well as the experience of its affiliate The Vermont Health Plan (TVHP). The expected amount of large claims is presented as a percent of overall claims.

   BCBSVT utilized the BCBSVT/TVHP allowed claims experience paid through September 2013 for calendar years 2011 and 2012. Since the analysis is performed at the aggregate allowed level, the different products will not affect the underlying data set and analysis.

   In prior filings, all managed mental health claims were excluded from the data set because the coverage was capitated and provided via an external vendor. Because managed mental health coverage is now provided by BCBSVT, all experience for mental health coverage was included in this analysis.

   The experience data set was trended forward using 4.1%. Calendar year 2012 data was given twice the weight of 2011 to give more emphasis to recent experience and add statistical credibility.

   Typically, a company's large claim experience is not statistically credible for projection purposes. Supplemental data is needed when the data set is not statistically credible enough. BCBSVT supplemented with 2013 Milliman Health Cost Guidelines. The Milliman factors were blended with the Company's experience factors using a credibility factor. The credibility formula assigns a factor of 100% for an attachment point of $30,000 down to 1% for an attachment point of $195,000. The attachment point limits were established in a Q1 2008 filing.

BCBSVT provided Actual to Expected exhibits for Calendar Year 2011 and Calendar Year 2012 for various attachment points.

2. *Cost of Reinsurance*: BCBSVT purchased reinsurance for claims in excess of $600,000 for 2014. The Company estimated the PMPM using a 75% loss ratio.

L&E Analysis

1. *Large Claim Factors and Pooling Charges*: When developing large claim factors and pooling charges, creating a reliable and statistically credible data set can be challenging. BCBSVT has combined data from both BCBSVT/TVHP Merit groups and BCBSVT Cost Plus groups. This appears to be reasonable and appropriate in order to create a large and credible data set for setting these factors.

   The Company used calendar years 2011 and 2012 with 2012 weighted twice as much as 2011 for the data set. The claims have been run out through September 2013. This methodology for weighting and run out is consistent with the 2013 Provision for Large Claims & Stop Loss Filing (SERFF # BCVT-128809318, VFN 63456). The timeframe of the data set is reasonable and appropriate, utilizing full calendar year data with ample time for outstanding claims to be paid.

   The addition of the all managed mental health claims in this data set is appropriate since this coverage is now provided by BCBSVT. The experience data set was trended using 4.1%. The development of the data set appears to be reasonable and appropriate.

   Company experience was supplemented with 2013 Milliman Health Cost Guidelines, which is appropriate when the Company's experience is not credible. We requested additional information about the credibility formula and its appropriateness. The current credibility formula assigns a factor of 100% for an attachment point of $38,000 down to a factor of 1% for an attachment point of $248,000. These limits have been trended from Q1 2008. The Company provided additional information regarding a study that was performed for the 2008 filing. The 2008 filing indicated that the variability below $30,000 was small and increased up to $200,000. The credibility formula and methodology appear to be reasonable and appropriate.

   The Actual to Expected (A2E) exhibits show the similarities and differences in the actual to expected ratios. A2E exhibits are useful for determining how a company's expected pricing has compared to the actual amounts. For large claim analysis, A2E exhibits do not account for the credibility of the data set and do not include trend to the rating period.

   Since the results have varied greatly over the last two calendar years, we requested a similar exhibit with both calendar years combined. As attachment points increase, the amount of data at these claim levels decreases, which results in the Milliman factors having a greater influence on the factors proposed in this filing. The Milliman data is larger and more credible than BCBSVT's data. We reviewed the A2E exhibits for overall reasonableness, but we did not use these exhibits exclusively because of the lack of credibility at the average attachment point for these types of groups.

The overall factor changes are:

- Merit: Large claim factors increased on average from 11.6% to 13.9%
- Cost Plus: Pooling charges increased from 2.2% to 3.2%.

Given that the average credibility factor used is 0%, these changes are primarily based on changes in the Milliman factors. BCBSVT stated that the increase in the Milliman factors, especially at the tail of claims distribution, is likely due to the elimination of lifetime maximums through PPACA. This appears reasonable and appropriate based on common industry practices.

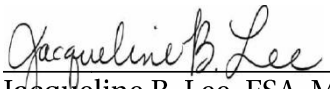
The overall rate impact of these factor changes results in an increase of approximately $4 PMPM on rates (~1%). The proposed factor changes and methodology in determining these changes appear to be reasonable and appropriate.

2. *Cost of Reinsurance*: We noted an increase in the estimated PMPM for the Cost of Reinsurance for the Merit groups. In the correspondence, BCBSVT noted that they had changes to the reinsurance coverage. In 2013, BCBSVT had reinsurance coverage for claims in excess of $650,000. Beginning in 2014, BCBSVT changed the contract coverage to claims in excess of $600,000. Notwithstanding other potential changes, this alone would increase the cost of coverage.

   The Company provided an A2E exhibit that showed that the estimates were in line with the actual costs. The increase from $0.53 PMPM to $1.05 PMPM appears to be solely due to the change in contract terms. The methodology and estimates of the Cost of Reinsurance appear to be reasonable, appropriate, and in line with estimates in prior filings.

Recommendation
L&E believes that this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board approve the filing as requested.

Sincerely,



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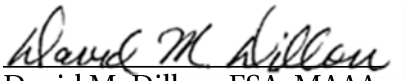

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ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations1, promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct2, to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

Identification of the Responsible Actuary
The responsible actuaries are:

- Jacqueline B. Lee, FSA, MAAA, Vice President at Lewis & Ellis, Inc. (L&E).
- Joshua A. Hammerquist, ASA, MAAA, Assistant Vice President at Lewis & Ellis, Inc. (L&E).
- David M. Dillon, FSA, MAAA, MS, Vice President & Principal at Lewis & Ellis, Inc. (L&E).

These actuaries are available to provide supplementary information and explanation. The actuaries also acknowledge that they may be acting as an advocate.

Identification of Actuarial Documents

The date of this document is March 14, 2014. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is February 25, 2014.

Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the Green Mountain Care Board. The authors of this report are aware that it will be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is financially and organizationally independent from the health insurance issuers whose rate filings were reviewed. There is nothing that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the Board in assessing whether to approve, modify, or disapprove the rate filing.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- Lewis & Ellis has reviewed the data provided by the issuers for reasonableness, but we have not audited it. L&E nor the responsible actuaries assume responsibility for these items that may have a material impact on the analysis. To the extent that there are

[1] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.

[2] These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.
- We are not aware of any subsequent events that may have a material effect on the findings.
- There are no other documents or files that accompany this report.
- The findings of this report are enclosed herein.

Actuarial Findings
The actuarial findings of the report can be found in the body of this report.

Methods, Procedures, Assumptions, and Data
The methods, procedures, assumptions and data used by the actuary can be found in body of this report.

Assumptions or Methods Prescribed by Law
This report was prepared as prescribed by applicable law, statues, regulations and other legally binding authority.

Responsibility for Assumptions and Methods
The actuaries do not disclaim responsibility for material assumptions or methods.

Deviation from the Guidance of an ASOP
The actuaries have not deviated materially from the guidance set forth in an applicable ASOP.